STATE HOSPITAL REFERRAL FORM

State Form 52179 (7-05)/CS 0020
Indiana Family and Social Services Administration
Division of Mental Health and Addiction

Referral Date:

Update:

Patient Name (*last, first, middle, maiden*):	Birth Date:	Social Security #:	Sex: ☐ Male ☐ Female

Home Address:	Telephone #:	Primary Language:
City/State/ Zip:	County:	Previous SOFs:

MARITAL STATUS:
- ☐ Married
- ☐ Divorced
- ☐ Single
- ☐ Widowed

COMMITMENT STATUS:
- ☐ Temporary Commitment
- ☐ I C S T
- ☐ Extended Temporary
- ☐ Commitment Pending
- ☐ Regular Commitment
- ☐ Voluntary

Date of Commitment: _____
County of Commitment: _____

Any outstanding legal charges? ☐ Yes ☐ No
County: _____
Explain:

Check if:
- ☐ Health Care Representative
- ☐ Custodial Parent
- ☐ Legal Guardian

Name:

Relationship:

Address:

Telephone #:

Insurance: Numbers:
- ☐ Medicare _____
- ☐ Medicaid _____
- ☐ Other _____

Financial Resources:
- ☐ SSD $ _____
- ☐ SSI $ _____
- ☐ VA $ _____
- ☐ Other $ _____

Payee:
- ☐ Self
- ☐ Other

Payee Name:

Address:

PSYCHIATRIC INFORMATION

Current Placement:	Address:	Date Admitted:

Diagnoses Axis I:
Axis II:
Axis III:

GAF: Past 12 months _____
GAF: Current _____

Current Symptoms and Behaviors:

Brief History (*presenting problems/risks including self harm, aggression, elopement, falls*):

Current Medications and Dosages:	Recent Medication Changes – Why?

TREATING PHYSICIAN

Name:	Telephone #:

MEDICAL NEEDS / SPECIAL NEEDS

☐ Diet	☐ Communicable Disease	☐ GU Tract - Urinary (*dialysis, incontinence, catheter, etc*.)
☐ Mobility	☐ Medical Equipment	☐ Diabetes
☐ Hearing Impairment	☐ Circulatory Issues (*Heart Disease, HTN, etc*.)	☐ Neurological (*seizures, NMS, altered* gait)
☐ Visual Impairment	☐ Respiratory (*COPD, asthma*)	☐ Diabetic
☐ Communication Difficulty	☐ GI Tract (*ulcers, gastric reflux, colostomy G-tube, etc*.)	☐ Suicidal
☐ Allergies		☐ Assaultive
☐ Past History of T.B. PPD – Results _____		

Explain any items checked above and current treatment, if applicable. Copy of current physical may be used if current treatment is included. Attach additional sheets if necessary.

Expectations of hospitalization and anticipated length of stay – specific and measurable goals for community reintegration:

GATEKEEPER / DISCHARGE PLAN - Community Placement Needs

Assigned Gatekeeper:

Hospital Liaison:	Telephone #:
Address:	Date:
City / State / ZIP:	Signature:

☐ SGL (24m) SMI/SA/SED	☐ DOC (*forensic only*)
☐ SGL (24m) MR/DD	☐ Locked or Subacute
☐ Supported Living - MR/DD only	☐ RBA
☐ ICF/MR Facility - MR/DD only	☐ Halfway Program – Chemical Addiction
☐ Family Personal Home	☐ AFA
☐ Specialized Residential Facility	☐ Therapeutic Foster Care
☐ Medical or Nursing Facility	☐ Other: _____
☐ Cluster Apt. Setting or SILP	

GATEKEEPER / DISCHARGE PLAN - Post SOF Program Needs

☐ Day Treatment / Partial Hospitalization	☐ SOC – Systems of Care (SED)
☐ Intensive Outpatient	☐ Children's Medicaid Waiver
☐ Medication Evaluation & Monitoring	☐ Recreational Therapy – MR/DD only
☐ Case Management	☐ Behavioral Modification & Support – MR/DD only
☐ Substance Abuse Aftercare	☐ Community Habilitation – MR/DD only
☐ Vocational & Employment Services	☐ Health Care Coordination – MR/DD only
☐ ACT – Assertive Community Treatment	☐ Prevocational/Sheltered Employment – MR/DD only
☐ IDDT – Integrated Dual Diagnosis Treatment	☐ Other: _____

STATE HOSPITAL REFERRAL FORM DIRECTIONS

When admission to a state hospital is determined appropriate by the Gatekeeper, the State Hospital Referral Form is to be completed, signed by the Gatekeeper and forwarded to the appropriate state hospital with the documents as listed below. Upon receipt of the form and required documents, the state hospital will contact the Gatekeeper within two working days regarding service / bed availability / waiting list.

The following documents are required with the Admission Referral Form:

- Current mental status (*most recent psychiatric assessment*) and significant findings
- Current risk factors (*self-harm, aggression, elopement, falls, etc*.)
- Most recent physical examination
- Any pertinent medical workups
- Commitment papers (*or as soon as available; must be prior to admission*)
- Legal papers (*guardianship, wardship, legal charges, etc*.)
- Current treatment plan (*include current medications with dosages*)
- Current psychological testing scores if available

Exceptions are:

- Result of TB test (*date given and read*). Test preferred within 30 days but required within 90 days prior to admission

Additional documentation is required for MR/DD and Child/Youth Referrals with the Admission Referral form:

MR/DD Referrals

- Diagnostic and Evaluation
- DD Eligibility if Determined
- BDDS Involvement
- CMHC Screening
- School History and Education (*IEP if available*)
- Psychological testing scores and person/place to contact

Child/Youth Referrals - SED Waiver Enrollment

- Immunization
- School History & Education, Records & IEP (*psychoeducational evaluation, if possible*)
- History of Past Treatment
- Birth Certificate
- Institutional Level of Care

The Admission Referral Form must be submitted again at the time of admission to the state hospital. Only those sections noting changes since the referral (*medication changes, legal changes, etc*.) must be completed. This is to insure that the state hospitals have current information at admission. If the patient information remains the same as at the time of submission of the referral packet, you must submit the admission referral form again and indicate in the "Update" box, "No Changes." DMHA will be implementing a monitoring form to be used by admission staff at the state hospitals.